BALTIMORE CITY HEALTH DEPARTMENT
RYAN WHITE CARE ACT, TITLE I
QUALITY IMPROVEMENT PROGRAM (QIP)

STANDARDS OF CARE COMPARATIVE ANALYSIS:
PRIMARY CARE
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PREPARED BY:

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COMPARATIVE ANALYSIS OF PRIMARY CARE STANDARDS OF CARE: BALTIMORE EMA AND THE U.S. PUBLIC HEALTH SERVICE

Section 1. Process & Development of Tools

Three Standards of Care documents were used to develop the Quality Improvement Project (QIP) instrument for adult primary care:

1. Greater Baltimore HIV Health Services Planning Council, *Standards of Care for Health Services and Support Services*, ratified August 2001.
2. U.S. Department of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents,* August 13, 2001.
3. *USPHS/ISDA 2001 Guidelines for The Prevention Of Opportunistic Infections in Persons Infected With Human Immunodeficiency Virus*, November 28, 2001.

The existing Baltimore EMA Standards (EMA Standards) for adult primary care were compared with the current Federal standards (DHHS Treatment Guidelines) regarding the use of antiretroviral agents and the prevention and treatment of opportunistic infections (Table 1). Column 1 outlines the EMA Standard of Care and Column 2 outlines the DHHS Treatment Guidelines. In several instances, the DHHS Treatment Guidelines do not specifically address the individual Standards of Care. For example, the history of HIV-positive status is not addressed in the Federal guidelines. In those instances, Column 2 is left blank. If the DHHS Treatment Guidelines addressed an EMA Standard, the specific guidelines and corresponding page number are noted in Column 2.

The review of the EMA Standards and the DHHS Treatment Guidelines led to the development of two primary care QIP instruments which focused on (1) the care provided to the individual client and (2) the agency's implementation and compliance with the relevant standards outlined by the EMA. The individual client instrument was completed by clinicians through review of and abstraction from the client chart. The agency instrument was completed by a representative of the Title I vendor.

Section 2. EMA Standards

The EMA Standards are divided into two major components: 1) expectations for direct patient care; and 2) key components of the system of care.

The expectations for direct patient care focus around: a) the baseline medical evaluation; b) follow up visits; and c) centralized problem lists. Specific activities to undertake, values and conditions to monitor and issues to explore are outlined within the EMA Standards. In several instances, the level of detail outlined in the EMA Standards meets or exceeds the DHHS Treatment Guidelines.

The key components of the system of care address concepts such as: a) licensing and provider experience; b) patient rights and confidentiality; c) access to care and provider continuity; and d) quality improvement. Most of these items are not addressed in the DHHS Treatment Guidelines as they appropriately focus more intently on the clinical use of antiretroviral treatment (HAART) and the prevention of opportunistic infections.

For each EMA Standard, Table 1 outlines the strengths and weaknesses and, as appropriate, provides recommendations.

Section 3. Recommendations

As noted in the DHHS Treatment Guidelines, "concepts relevant to HIV management evolve rapidly"[1]. Since the ratification of the EMA standards for adult HIV primary care in September 1998, the DHHS Adult and Adolescent Treatment Guidelines have been revised seven times[2] and the opportunistic infection guidelines have been revised four times[3]. The pediatric and perinatal transmission Treatment Guidelines have been similarly revised by the DHHS.

The Baltimore Health Services Committee, which drafted the EMA standards, recognize that "treatment protocols for HIV-positive individuals are changing rapidly, both committees recognize that the Standards which reflect the minimum level of service that must be given by a Ryan White Title I funded provider, must be reviewed regularly and redrafted to reflect the latest in quality treatment or service."[4]

Because of the frequency of revision to these Federal guidelines, it would be unrealistic for the EMA standards to be as specific as the Federal guidelines. Appropriately, the EMA standards incorporate the "initiation of treatment using the most recent protocols as guidelines" into its standards (standard 1.1.k). Rather than revising the EMA standards as treatment guidelines are updated, increased efforts might be placed on ensuring the Title I vendors are aware of the updates and assisting the providers to incorporate these changes into their primary care services. This effort may be facilitated by the Baltimore-based providers who serve on the Federal panels which develop the Treatment Guidelines and/or the HRSA-supported Pennsylvania/Mid-Atlantic AIDS Education Training Center.

While the Federal Treatment Guidelines are very specific and prescriptive, some of the EMA standards are not adequately descriptive to provide guidance to the provision of care. For example standards relating to risk reduction counseling and patient education, coordination with other disciplines—particularly with social work and case management services, and discussion of advanced directives, could be more clearly defined based on current research and

[1] USDHHS, p. iii.
[2] Revisions to the initial April 24, 1998 treatment guidelines have been made on December 1, 1998; May 5, 1999; January 28, 2000; February 5, 2001; April 23, 2001; August 13, 2001; and February 4, 2002.
[3] Revisions to the opportunistic infection guidelines were released on May 14, 1999; August 20, 1999; July 2001; and November 28, 2001 per www.hivatis.org.
[4] Greater Baltimore HIV Health Services Planning Council, Section 1, Page 1.

best practices to assist the providers in operationalizing these standards. Specific criteria and expectations could be provided to give better guidance to primary care providers.

To further delineate the key activities related to baseline medical evaluations and ongoing care, it might be appropriate to divide Standard 1.2 "Follow up visits" into two subcategories: 1) ongoing care; and 2) annual care. Ongoing care would include activities that should be completed at every visit, such as temperature, problem list updates and review of CD4 counts and medications. Annual care would include items such as PPD testing, pap smears and syphilis serology.

In the 2001 ratified Standards, a section labeled "Outcomes for Adult HIV Primary Medical Care" focused on three issues: 1) adherence to medical appointments; 2) CD4 counts; and 3) PCP prophylaxis. The information is more accurately depicted as decision trees designed to help providers with treatment decisions.

Table 1. Comparison between the Baltimore EMA standards for adult HIV primary care and DHHS Treatment Guidelines[5]

Numbers in parenthesis indicate page number in DHHS Treatment Guidelines publication.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.1	**Baseline Medical Evaluation**			
1.1a	History of HIV-positive status, including route of transmission, when first diagnosed		S: Meets the Title I legislative requirement for documentation purposes.	None
1.1b	Confirmation of HIV-positive status by serology		S: Meets the Title I legislative requirements for documentation purposes.	None
1.1c	Documentation of annual PPD placement and test results. • Documented attempts to contact clients who do not return for PPD reading • If PPD test is positive, obtain chest x-ray • If negative for active TB, prophylactic therapy must be given	Although the reliability of the TST might diminish as the CD4+ T-lymphocyte count declines, annual repeat testing should be considered for HIV-infected persons who are TST-negative on initial evaluation and who belong to populations in which there is a substantial risk for exposure to *M. tuberculosis* (BIII). Clinicians should consider repeating the TST for persons whose initial skin test was negative and whose immune function has improved in response to HAART (i.e., those whose CD4+ T-lymphocyte count has increased to greater than 200 cells/µL) [p. 14] Prophylaxis of opportunistic infections; see standard 1.2.g	S: Documentation of placement and results meets the DHHS guidelines. S: Documentation of attempts to contact clients exceeds DHHS guidelines. W: Repeating TSTs for persons with improved immune function is not addressed.	Encourage use of annual testing for members of HIV risk populations. Define "HIV risk" populations and ensure vendors have a clear understanding of which populations have a substantial risk for exposure. Attention to DHHS guidelines is warranted. Information related to annual care should be consolidated into one section and identified as "Annual Care". PPD testing should be included as part of the annual care requirements.

[5] As noted above, federal guidelines used were the U.S. Department of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents,* August 13, 2001 and USPHS/ISDA 2001 Guidelines for The Prevention Of Opportunistic Infections in Persons Infected With Human Immunodeficiency Virus, November 28, 2001, which were the most current documents at the time.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.1d	Reproductive history; including hx of menses, contraception, pregnancy, childbirth and PAP smear results		S: Addresses issues specific to women.	None
1.1e	Baseline body weight, “normal weight”, height and vital signs		S: Obtains baseline information.	None

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.1f	Laboratory data: • CBC with platelets • Chemistry panel • LFTs (chol, triglycerides, glucose only for those to be treated with PIs) • CD4 • Viral load • Syphilis • Toxoplasma IgG (repeat toxo test if CD4 <100) • CMV IgG • Hepatitis B and C	• Viral load at diagnosis of infection (p. 2) • CD4+ counts at diagnosis (p. 2) • Lipid studies (p. 21) Additional evaluation should include routine tests pertinent to the prevention of OIs, if not already performed (RPR or VDRL, tuberculin skin test, toxoplasma IgG serology, and gynecologic exam with Pap smear), and other tests as clinically indicated (e.g., chest X-ray, hepatitis C virus (HCV) serology, ophthalmologic exam) (AII). Hepatitis B virus (HBV) serology is indicated in a patient who is a candidate for the hepatitis B vaccine or has abnormal liver function tests (AII), and CMV serology may be useful in certain individuals, as discussed in the "USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with the Human Immunodeficiency Virus" *[2]* (BIII).	S: Meets the DHHS guidelines.	Information related to annual care should be consolidated into one section and identified as "Annual Care". Repeat of toxo test for clients with CD4 counts <100 should be included as part of the annual care requirements.
1.1g	Assessment/hx of mental health, substance abuse, and appropriate referrals made, if needed		S: Assesses client needs beyond medical care.	None

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.1h	Assessment of vaccinations, including dates of Pneumovax and influenza	Prophylaxis of opportunistic infections; see standard 1.2.g	S: Meets the DHHS guidelines.	None
1.1i	• Documentation of discussion of safer sex practices. • Screening of barriers that may affect compliance or adherence to medications and treatment. • Establish a relationship between the medical provider and patient.	Providers should assess and assist adherence at the initiation of therapy (p. 9)	S: Denotes importance of safer sex practices for both men and women and screening for barriers to adherence.	None
1.1j	Initiation of treatment using the most recent protocols as guidelines. Documentation of on-going discussions regarding: ▪ Side effects ▪ Dosing schedule ▪ Related adherence issues	Before initiating therapy obtain (p. 6): • H + P • CBC, CMP, CD4+ count, viral load • RPR/VDRL • PPD • Toxoplasma IgG • Pelvic exam • Add other tests as clinically indicated (e.g., chest x-ray, HBV, HAV, HCB, ophthalmic exam, CMV) • Asymptomatic patients should be on antiretroviral therapy if their CD4+ count is < 200 (p. 8) • Asymptomatic patients should be offered antiretroviral therapy if their CD4+ count is < 350. There should be a complex discussion with the patient on the risks and benefits. (p. 9) • Antiretroviral therapy for symptomatic disease including wasting, thrush, fever for > 2 weeks or AIDS	S: Appropriately defers to the most recent DHHS guidelines. S: Outlines specific issues to discuss with client and documentation of such discussion. W: Past use of HAART and level of adherence is not specifically delineated as part of the baseline medical evaluation.	Information related to ongoing care should be consolidated into one section and identified as "Ongoing Care". Documentation of discussions should be included as part of the ongoing care requirements. History of past HAART should be assessed during the baseline medical evaluation and level of adherence documented.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
		defining illness (p. 6) • Providers should assess and assist adherence at the initiation of therapy (p. 9) Regimes for initial treatment of antiretroviral naïve patients (p. 46): <u>Column A</u> Efavirenz Indinavir Nelfinavir Ritonavir + Indinavir Ritonavir + Lopinavir Ritonavir + Saquinavir <u>Column B</u> ddI + Lamivudine Stavudine + ddI Stavudine + Lamivudine ZDV + ddI ZDV + Lamivudine • *Pick one from column A and one from column B		

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.2	Follow up visits			
1.2a	Temperature, vital signs and weight		S: Updates health status.	None
1.2b	Problem list status and updates		S: Updates information related to health status.	None

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.2c	Assessment and reinforcement with treatment plan at every visit	Suboptimal declines in viral load should be evaluated by considering adherence, malabsorption, repeat viral load and/or by changing drug regimen (p. 2). Providers should assess and assist adherence at the initiation of therapy and during the course of therapy (p. 9).	W: EMA Standard does not address documentation of assessment and reinforcement.	Revise the Standard to outline the methods of reinforcement used and documentation of assessment and reinforcement.
1.2d	Laboratory: • CD4 at diagnosis & q 3-6 mos. • Viral load at diagnosis & q 3-4 mos. • Viral load before initiating therapy • Viral load 2 – 8 weeks after initiating therapy • Repeat viral load when a change in therapy is considered	• CD4+ counts every 3 – 6 months (p. 2) • Viral load every 3 – 4 months if not treating (p. 2) • Viral load before initiating therapy (p. 2) • Viral load 2 – 8 weeks after initiating therapy (p. 2) • Viral load every 3 – 4 months while on therapy (p. 3) • Viral load before changing therapy (p. 2)	S: Meets the DHHS guidelines.	Add a statement indicating laboratory tests should be conducted according to the most recent DHHS guidelines. Ensure that all vendors are aware of changes of DHHS guidelines.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.2e	Resistance testing considered when suboptimal suppression of viral load is noted within 4-6 mos.	Consider changing therapy (p. 23 - 24): • Incomplete therapy (non-HAART) • Viremia reappears after initial suppression • Viremia not suppressed (less than 0.5 logs in 4 weeks, 1 log in 8 weeks, detectable or nearly so compared to baseline after 4 – 6 months) • Reproducible significant increase of 3x from nadir • Persistently declining CD4+ count on more than one measure • Clinical deterioration When changing therapy conduct (p. 23): • H + P • viral load (twice) • CD4+ count • Assessment of adherence • Resistance testing	W: Specific reasons to change regimens are not outlined. Specific laboratory results to obtain when therapy is changed are not outlined.	Revise standard to reflect use of most recent DHHS guidelines as guide for changing therapy. Outline specific laboratory results to obtain when therapy is changed.
1.2f	Address reduction of high risk behavior for HIV transmission	"On-going prevention counseling is an essential component of the management of a person with HIV infection" (p. 29)	S: Outlines need to prevent further transmission. W: "High risk behavior" is not defined. Frequency of addressing high risk behavior is not outlined.	Define high risk behavior. Specify the frequency, methods and documentation of addressing high risk behavior.
1.2g	Prophylaxis of opportunistic infections (OIs) per treatment guidelines -Documentation of current therapies on	Prophylaxis to prevent first episode of opportunistic disease in adults	S: Appropriately refers to the DHHS guidelines.	None

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
	all patients receiving prophylaxis	1.2g (source: 2001 USPHS/IDSA Guidelines) Group A: Strongly recommended as standard of care **1. Pneumocystis carinii** Indication: CD4+ count <200 or oropharyngeal candidiasis First choice: TMP-SMZ, 1 DS po qd Alternatives: • Dapsone, 50 mg po bid, or 100 mg ph qd; dapsone 50 mg po qd plus pyrimethamine, 50 mg po qw plus leucovorin, 25 mg po qw • Dapsone, 200 mg po plus pyrimethamine, 75mg po plus leucovorin, 25 mg po qw • Aerosolized pentamidine, 300 mg q month • Atovaquone, 1500 mg po qd • TMP-SMZ, DS po tiw **2. Mycobacterium avium complex** Indication: CD4+ count < 50 First choice: Azithromycin, 1,200 mg po qw, or clarithromycin, 500 mg po bid Alternatives: • Rifabutin, 300 mg po qd		

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
		• Azithromycin, 1,200 mg po qw plus rifabutin, 300 mg po qd **3. Toxoplasma gondi** Indication: IgG antibody to Toxoplasma and CD4+ count <100 First choice: TMP-SMZ 1 DS po qd Alternatives: • TMP-SMZ, 1 SS po qd • Dapsone, 50 mg po qd plus pyrimethamine, 50 mg po qw plus leucovorin, 25 mg po qw • Dapsone, 200 mg po plus pyrimethamine, 75 mg po plus leucovorin, 25 mg qw • Atovaquone, 1,500 mg po qd with or without pyrimethamine, 25 mg po qd plus leucovorin, 10 mg po qd **4. Varicella zoster virus (VZV)** Indication: Significant exposure to chickenpox or shingles for patients who have no history of either condition or, if available, negative antibody to VZV First choice: Varicella zoster immune globulin (VZIG), 5 vials (1.25 ml each) IM, administered < 96 hours after exposure, ideally within 48 hours **5. Mycobacterium**		

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
		tuberculosis Isoniazid-sensitive Indication: TST reaction >5mm or prior positive TST results without treatment or contact with case of active tuberculosis regardless of TST result. First choice: Isoniazid, 300 mg po plus pyridoxine, 50 mg po qd x 9 months; or Isoniazid, 900 mg po plus 100 mg pyridoxine, 100 mg po biw x 9 months Alternatives: • Rifampin, 600 mg po qd x 4 months; or • Rifabuin, 300 mg po qd x 4 months • Pyrazinamide, 15-20 mg/kg po qd x 2 months plus either rifampin, 600 mg po qd x 2 months or rifabutin, 300 mg po qd x 2 months Isoniazid-resistant Indication: Same as above; high probability of exposure to isoniazid-resistant tuberculosis First choice: Rifampin 600 mr po qd x 4 months; or Rifabutin, 300 mg po qd x 4 months		

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
		Alternatives: Pyrazinamide, 15-20 mg/kg po qd x 2 months plus either rifampin, 600 mg po qd x 2 months or rifabutin, 300 mg po qd x 2 months Multidrug-(isoniazid and rifampin) resistant Indication: Same as above; high probability of exposure to multidrug-resistant tuberculosis First choice: Choice of drugs requires consultation with public health authorities. Depends on susceptibility of isolate from source patient. Group B. Generally recommended **6. Streptococcus pneumonia** Indication: CD4+ count >200 First Choice: 23 valient polysaccharide vaccine, 0.5 ml IM Alternatives: None **7. Hepatitis B virus** Indication: All susceptible (anti-HBc negative patients) First choice: Hepatitis B vaccine, 3 doses Alternatives: None 8. **Influenza virus**		

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
		Indication: All patients (annually, before influenza season) First choice: Inactivated trivalent influenza virus vaccine; one annual dose (0.5 ml) IM Alternatives: • Oseltamivir, 75 mg po qd (influenza A or B) • Rimantadine, 100 mg po bid • Amantadine, 100 mg po bid (influenza A only) 9. **Hepatitis A virus** Indication: All susceptible (anti-HAV negative patients) at increased risk for HAV infection (e.g., illicit drug users, men who have sex with men, hemophiliacs) or with chronic liver disease, including chronic hepatitis B or hepatitis C First choice: Hepatitis A vaccine, 2 doses Alternatives: None Group C: Evidence for efficacy, but not routinely indicated 10. **Bacteria** Indication: Neutropenia First choice: G-CSF, 5-10 ug/kg sc qd x 2-4 weeks or GM-CSF 250 ug/m2 sc/iv x 2-4 weeks Alternatives: None. 11. **Cryptococcus Neoformans**		

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
		Indication: CD4+ count < 50 First choice: Fluconzaole, 100-200 mg po qd Alternative: Itraconazole capsule, 200 mg po qd 12. **Histoplasma Capsulatum** Indication: CD4 count <100, endemic geographic area First choice: Itraconazole capsule, 200 mg po qd Alternatives: None 13. **Cytomeglavirus (CMV)** Indication: CD4 count < 50 and CMV antibody positive First choice: oral ganciclovir, 1g po tid Alternatives None		
1.2h	Women: Documentation a pap smear within previous 12 months. • Follow-up with 2nd smear for initial normal smear after 6 months; if both negative, then q 12 months. • Re-evaluation of smear showing severe inflammation or reactive changes within 3 to 6 months. • Colposcopic examine of lower genital track for dx of SIL or atypical squamous cells of undetermined significance.		S: Women's health needs are being addressed.	Ensure providers receive the most recent guidelines related to care for women. [Anderson, Jean, ed. A Guide to the Clinical Care of Women with HIV. GPO, 2001].

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.2i	Recording of results of PPD. Recorded attempts to follow-up with clients who do not return for PPD reading. For all positive PPD tests of at least 5 mm induration: prophylaxis with recommended agents, CXR or documentation that appropriate prophylaxis regimens had been completed.	Prophylaxis of opportunistic infections; see standard 1.2.g	S: Meets DHHS guidelines	None
1.2j	Annual syphilis serology		S: Outlines the need to test for syphilis on an annual basis. W: Annual testing for syphilis may not be sufficient to address the high STD rates within the EMA.	CDC recommendations related to STDs and high risk populations should be reviewed to determine other appropriate standards beyond annual testing. [CDC, May 10, 2002. "Sexually transmitted diseases treatment guidelines 2002", *MMWR*, 51 (RR-6)] Information related to annual care should be consolidated into one section and identified as "Annual Care". Annual syphilis serology should be included as part of the annual care requirements.
1.2k	Address advance directives, including "DNR" status at an appropriate time in the course of illness.		S: Outlines the need to discuss advance directives. W: The specific timeframe or frequency when advance directives are to be addressed is not outlined.	Advance directives including durable powers of attorney, living will, and other planning documents (e.g., standby guardianship) should be addressed with all clients upon intake and at specified intervals. The frequency should be defined.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.2l	Documentation of reporting all reportable illnesses to the local health department.		S: Outlines the need to report infectious diseases.	Ensure all providers are aware of which diseases are reportable in Maryland (see attached).
1.2 m	If CD4<100, Ophthalmic examination by a trained retinal specialist q 6 months, or as recommended by that specialist.		S: Outlines the need for ophthalmic examinations.	None
1.2n	Discussion of safer sex practices, as appropriate	See 1.2.f above	S: Highlights the need for continued discussion with clients. W: Requirements for documenting such discussions are not outlined.	Define documentation and documentation requirements.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
1.3	**Central Problem List separate from progress notes which prioritizes problems for primary care management**			
1.3a	Includes history and activity of mental health and substance abuse disorders		S: Documents co-morbid conditions.	None
1.3b	Location/provider of ancillary continuing healthcare (e.g., mental health or substance abuse, or other continuing specialty service)		S: Identifies other service providers.	None
1.3c	Need for and provider of case management services.		S: Identifies other service providers involved in the client's care.	None

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
2.1	**Licensing, Knowledge, Skills and Experience**			
2.1a	Organizational licensure Professional licensure of all staff delivering health services		S: Specifies level of education and training of health care staff.	None

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
2.1b	Professional supervision of staff or consultation provided by practitioners who have extensive HIV experience and active HIV practices themselves.		S: Specifies need for professional oversight of experienced practitioner.	None
2.1c	Staff providing direct HIV clinical services should have an active practice of > 20 HIV+ patients. Encourage medical practitioners to develop the "expertise" needed to provide the specialized care that HIV infected patients need.		S: Identifies minimum number of HIV-positive clients being seen by qualified provider.	None
2.1d	Clinical staff have a minimum of 30 CME hours per year in HIV/AIDS specialty course work.		S: Outlines need to remain current in HIV care.	Ensure primary care agencies have a system in place to document CME hours for clinical staff.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
2.2	**Patient Rights and Confidentiality**			
2.2a	The protection of patient rights and responsibilities		W: The sentence is not complete. W: The specific rights and responsibilities are not identified.	Define patients' rights and responsibilities, which as a minimum, comply with current law and regulatory requirements or incorporate this Standard with 2.2b and 2.2c. May want to develop a list of patients rights and responsibilities for all Title I service categories instead of for each service category.
2.2b	Assurance of patient confidentiality with regard to medical information transmission, maintenance and security		S: Outlines specific patient rights	Define current legal and regulatory requirements.
2.2c	Written policies regarding: • Grievance • Confidentiality • Eligibility for service • Patients rights and provider expectations of patients and termination of care by either the patient or the provider.		S: Identifies specific policies that should be established to maintain patient rights and confidentiality.	None

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
2.3	**Access, Care and Provider Continuity**			
2.3a	Time-appropriate delivery of services, including 24-hour call coverage		S: Identifies need for 24-hour call coverage	None
2.3b	Mechanisms for urgent care evaluation and/or triage		S: Outlines plan for urgent care	None

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
2.3c	Mechanisms for inpatient care (or referral) and return to ambulatory care		S: Identifies the need for inpatient care. W: Specific requirements regarding discharge and coordination of care are not outlined.	Delineate expectations related to discharge from the inpatient setting.
2.3d	Documentation of follow-up attempts/outreach to reduce the no show rate.		S: Identifies need for follow-up with patient no-shows.	Delineate specific goals for no-show rates. Outline specific documentation requirements for outreach and follow up attempts.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
2.3e	Care services which include (or arranged by referral): 1. Medical subspecialties: i. Gastroenterology ii. Neurology iii. Psychiatry iv. Ophthalmology v. Dermatology vi. Obstetrics & Gynecology vii. Pulmonary viii. Oncology ix. Dentistry 2. Social work and case management services 3. Nutritional counseling from a Registered Dietician (staff or direct referral) 4. Substance abuse treatment services 5. ART counseling/therapy for pregnant women 6. Information with inherited coagulopathies and referral to the local federally funded hemophilia treatment center		S: Outlines range of services that might be needed by clients. W: Specific requirements related to follow-up of such referrals are not outlined.	Delineate requirements of tracking referrals, interdisciplinary collaboration and documenting outcomes.
2.3f	Coordination with Social Work and Case Management services		S: Identifies need for coordinating services. W: Specifics on how the coordination can occur is not outlined.	Delineate specific requirements of coordination activities.
2.3g	Continuity with referring providers		S: Identifies need to maintain continuity of care. W: Documentation regarding continuity of care is not outlined.	Delineate requirements regarding documentation.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
2.3h	Education of the patient/family/significant other and/or caregiver		S: Identifies need to provide education. W: Documentation regarding documentation is not outlined.	Delineate requirements regarding documentation.
2.3i	Access to clinical investigations		S: Identifies need to provide access to clinical trials. W: Documentation regarding access to clinical trials is not outlined.	Delineate requirements regarding documentation.

Column 1		*Column 2*	*Column 3*	*Column 4*
Baltimore EMA Standards		**DHHS Treatment Guidelines**	**Strengths/Weaknesses**	**Recommendations**
2.4	**Quality Improvement (assurance) activity, which identifies areas for improvement and the subsequent action taken.**			
2.4a	Written quality improvement plan		S: Outlines the need for a written quality improvement plan. W: Examples of indicators to monitor are not provided.	Provide examples of various indicators that could be monitored.